

# Fairview Park Hospital Volunteer Services

## Application for Youth Volunteer Program

A Youth Volunteer must be between the ages of 15-18 and serves Fairview Park Hospital without salary. He/she works within the hospital under the supervision of specified hospital personnel and the Volunteer Coordinator. The Youth Volunteer is accountable to Fairview Park Hospital Volunteer Services.

School \_\_\_\_\_ Grade (this year) \_\_\_\_\_

Applicant's Full Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
(Must be at least 15 by June 1<sup>st</sup>)

Address: \_\_\_\_\_  
City / State Zip Code

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Custodial Parent/Guardian: \_\_\_\_\_ Business/Cell Phone: (\_\_\_\_) \_\_\_\_\_

Shirt Size: S M L XL 2XL 3XL

Have you ever served as a Youth Volunteer? YES NO How long ? \_\_\_\_\_ Where? \_\_\_\_\_

Honors or organizations you participate in \_\_\_\_\_

Do you have an interest in a Health Care career? If Yes, explain \_\_\_\_\_  
Preference will be given to students who are considering entering the medical field as a career.

Person to contact incase of emergency: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Phone Number

**Character Reference**(other than relative). Individual who can attest to your character and dependability.

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Number of Years Known \_\_\_\_\_

Return the *completed* application, school transcript, letter of recommendation from your school teacher or counselor, copy of your immunization records, guardian consent form, and an essay explaining why you should be a part of the Fairview Park Hospital Youth Volunteer Program.

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*Office Use Only:*

# Fairview Park Hospital Volunteer Services

## Youth Volunteer Program

### Guardian Consent

I hereby permit my son / daughter:

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to join the Youth Volunteer Program of Fairview Park Hospital. I realize the responsibilities of the organization and will cooperate with my son/daughter to comply with the rules and regulations that have been adopted. I will assume responsibility for his/her transportation.

Additionally, I will cooperate with my son/daughter to comply with the established hospital health standards. This includes granting my permission for the employee health nurse to administer a PPD skin test to screen for tuberculosis, submitting a copy of my son/daughter's immunization record to be reviewed by employee health nurse, and consenting to my son/daughter taking any blood or urinalysis drug screen requested by the hospital. These measures are necessary to ensure the health and well-being of my child.

In the event of a medical emergency, I permit the physicians in the Emergency Department of Fairview Park Hospital to treat my son/daughter.

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Guardian's Signature

Date

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Youth Volunteer's Signature

Date

Please list any allergies or medical conditions:

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Fairview Park Hospital Volunteer Services  
Youth Volunteer Program

(Please include a copy of students' most recent transcripts)

Teacher or Counselor Recommendation

\_\_\_\_\_ is applying for participation in the Youth Volunteer Program at Fairview Park Hospital. Below please find my comments in regards to the student's performance in the following disciplines:

Conduct:

Ability to Understand and Follow Directions:

Initiative:

Attendance:

Punctuality:

Additional Comments:

\_\_\_\_\_ I recommend \_\_\_\_\_ for participation in the Youth Volunteer Program at Fairview Park Hospital.

\_\_\_\_\_ I do not recommend \_\_\_\_\_ for participation in the Youth Volunteer Program at Fairview Park Hospital.

\_\_\_\_\_/\_\_\_\_\_  
Signature Date